



NATIONAL TRANSPORTATION SAFETY BOARD

Office of Aviation Safety
Washington, D.C. 20594

March 3, 2015

Group Chairman's Factual Report

OPERATIONAL FACTORS

ANC14MA008

A. ACCIDENT

Operator: Hageland Aviation Services, dba Era Alaska
Location: St. Mary's, Alaska
Date: November, 29, 2013
Time: 1824 Alaska standard time
Airplane: Cessna 208B Caravan

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C. SUMMARY

On November 29, 2013, at 1824 Alaska standard time, a Cessna 208B Caravan airplane, N12373, sustained substantial damage after impacting terrain about 1 mile southeast of the St. Mary's Airport, St. Mary's, Alaska. The airplane was being operated by Hageland Aviation Services, Inc., dba Era Alaska, Anchorage, Alaska as flight 1453, a visual flight rules (VFR) scheduled commuter flight conducted under the provisions of 14 Code of Federal Regulations

Part 135. Of the 10 people on board, the commercial pilot and three passengers sustained fatal injuries, and six passengers sustained serious injuries. Night, instrument meteorological conditions (IMC) prevailed at the St. Mary's Airport at the time of the accident, and company flight following procedures were in effect. Flight 1453 departed from the Bethel Airport, Bethel, Alaska, at 1741 destined for Mountain Village, Alaska, and continuing to St. Mary's. Before reaching Mountain Village, the flight diverted to St. Mary's due to deteriorating weather. Witnesses on the ground at St. Mary's reported seeing the airplane fly over the airport at low altitude, traveling in a southeasterly direction. They continued to watch the airplane travel away from the airport, until its rotating beacon disappeared. Due to concerns about the airplane's direction and altitude, the witnesses attempted to raise the pilot on the radio, with no response. They then heard another aircraft on the radio report that there was an Emergency Locator Transmitter (ELT) going off in the vicinity of St. Mary's. After checking for the airplane's last reported position on the company's flight following software, a search was initiated.

About one hour after the search was initiated, the airplane was located, and rescue personnel confirmed that the pilot and two passengers were deceased. One passenger died after being transported to the local clinic. The six surviving passengers were evacuated to Anchorage for treatment.

D. DETAILS OF THE INVESTIGATION

On November 30, the operations group chairman traveled from Fairbanks, Alaska, to Anchorage arriving about 1300. Upon arrival, the group chairman traveled to the operator's main base located at the Ted Stevens Anchorage International Airport, Anchorage, Alaska, and the main maintenance base located at the Palmer Airport, Palmer, Alaska, to collect pertinent records. Between November 31 and December 2, telephone interviews were conducted of company personnel, and hospital room interviews were conducted in person with two of the surviving passengers. The operations group concluded the initial phase of its investigation on December 2.

On December 11, a formal request was submitted to the Federal Aviation Administration's (FAA) Accident Investigation Branch (AVP-100) requesting documents pertinent to the investigation, and an interview with the operator's current¹ FAA principal operations inspector (POI).

On December 15, interviews were conducted with the operator's director of operations, chief pilot, and the flight coordinators that were working at the company's Bethel base on the day of the accident.

On December 20, an additional formal request was submitted to AVP-100 requesting interviews with the operator's former POI and the frontline manager who supervised both the current and former POIs. In addition, the NTSB Operations Group Chairman requested that the former POI's interview be conducted before the frontline manager's interview. The FAA could not

¹ The current POI within the context of this document, refers to the POI assigned to the Hageland certificate at the time of the accident.

accommodate the request and was unable to make the interviewees available until April 11, 2014.

On January 9, 2014, an interview was conducted with the current FAA POI for Hageland Aviation Services' certificate.

On April 11, 2014, interviews were conducted with the FAA's frontline manager responsible for overseeing the certificate management team (CMT)² for Hageland and the former FAA POI for the Hageland certificate.

E. FACTUAL INFORMATION

1.0 History of Flight

On the day of the accident, the pilot arrived at the company office in St. Mary's about 0800, which was indicated by the pilot's flight and duty records. The accident flight was the pilot's fifth flight of the day. According to the flight manifest, flight 1453 was to depart the Bethel Airport with 8 adult passengers and 1 infant passenger (that was not listed on the flight manifest), making a stop in Mountain Village, and then proceeding to St. Mary's.

The company had recently incorporated a risk assessment program into their operational control procedures which required each flight be assigned a risk level on a scale of 1 to 4, with the intention of mitigating the hazards for high risk flights.

Before departure, the flight coordinator checked the weather and assigned the flight a risk level of 2, due to IMC conditions, contaminated runway, and night conditions. He assigned another flight coordinator to build the manifest which listed 8 passengers and a risk assessment level of 2.

The flight coordinators did not discuss with the pilot the risk assessment level assigned to the flight, current weather conditions or hazards, or ways to mitigate the hazards as required by the risk assessment program. Neither of the flight coordinators working the accident flight had been trained on the risk assessment program, and the risk assessment program was not integrated into the company manuals.

The flight was scheduled to depart at 1700 Alaska standard time, but for reasons unknown, was about 41 minutes late. Via radio, the pilot reported his departure from the Bethel airport to the company flight coordinator at 1741, with 10 souls on board and 4 hours of fuel.

According to a passenger, they had been flying approximately 30 minutes when the airplane entered thick fog. The airplane was picking up ice, and about ½ to ¾ of an inch of ice had accumulated on the lift strut.

² CMT within the context of this document, refers to the team of FAA Principle Inspector's assigned to oversee a certificate.

Upon crossing the Yukon River, the pilot made an announcement that they were diverting to St. Mary's due to deteriorating weather at Mountain Village.

Another passenger reported that no lights were visible, but she saw the ground about 30 feet below and was able to discern dark patches of trees.

A witness on the ground at the airport in St. Mary's reported seeing a low flying airplane pass overhead at about 300 to 400 feet above ground level, heading east-southeast; he could not positively identify the airplane but recognized the sound of a turbo-prop. He observed the beacon for a few seconds, and then the lights illuminated something white, and he lost sight of the beacon.

The airplane impacted the top of a ridge about 1 mile southeast of the St. Mary's airport, at an elevation of about 425 feet; it then traveled about 200 feet coming to rest at an elevation of about 530 feet, in an upright position.

The nearest official weather reporting station is the St. Mary's Airport (PASM). About 6 minutes before the accident, at 1816, an Aviation Routine Weather Report (METAR) was reporting: Wind, 230 degrees (True) at 7 knots; visibility, 3 statute miles; sky condition, overcast at 300 feet above ground level (agl); temperature, 18 degrees F; dew point, -32 degrees F; altimeter, 30.01 inches Hg.

At 1836, the METAR was reporting, in part: Wind, 240 degrees (True) at 6 knots; visibility, 2.5 statute miles; sky condition, overcast at 300 feet agl; temperature, 18 degrees F; dew point, -32 degrees F; altimeter, 30.01 inches Hg.

See the Meteorology Group Chairman's report for additional weather information.

2.0 Flight Crew Information

2.1 The Pilot

The pilot, Terry R. Hansen, age 68, held a commercial pilot certificate with airplane multi-engine land, airplane single-engine land and sea, and instrument airplane ratings. His most recent second-class medical certificate was issued on August 21, 2013, which contained the limitation that he must wear corrective lenses and possess glasses for near and intermediate vision.

A review of Hageland Aviation Services' personnel records³ indicated that the pilot completed his initial company training, which included pilot ground and flight training, and was assigned to fly Cessna 207A airplanes on December 18, 2012.

On February 11, 2013, the pilot completed initial Cessna 208 ground training. On June 14, 2013, recurrent ground training was completed; on June 19 flight training and checking were completed, and the pilot was assigned to fly Cessna 208B airplanes out of the St. Mary's base.

³ See attachment 2: Company Personnel Records

2.1.1 The Pilot's Flight Times

The pilot's flight times, based on Hageland Aviation Services' personnel records dated February 11, 2013 were as follows:

Total pilot flying time	25,000+ hours
Total Pilot-In-Command (PIC) time	24,000+ hours
Total Alaska (PIC) time	20,000+ hours
Total single engine land flying time	20,000+ hours
Total Cessna 208 time	1,800+ hours
Total Turbo-Prop time	1,800+ hours
Total Night	2,000+ hours
Instrument	1,600+ hours
Actual	1,600+ hours
Hood	200+ hours

2.1.2 Pilot Flight and Duty Times

Flight and duty records⁴ revealed that the pilot was on a 14-hour assigned duty day, starting at 0800 and ending at 2200.

In the month of September 2013, the pilot was on duty for 15 days, flew 60.5 hours, with 15 days off. In October 2013, the pilot was on duty for 16 days, flew 73.8 hours, and had 15 days off. The pilot was on duty November 1 to 16, 2013, flew 63.7 hours, was off duty from November 17 to 28 and returned to work on November 29, the day of the accident.

2.1.3 Pilot 72 Hour History

The pilot was off duty the three days before the accident.

On November 29, the day of the accident, his duty day started at 0800. He flew 4 trips, totaling about 4.4 hours, before the accident flight.

2.1.4 Pilot Medical and Pathological Information

A post mortem examination of the pilot was conducted under the authority of the State of Alaska Medical Examiner, Anchorage, Alaska, on December 2, 2013. The cause of death for the pilot was attributed to multiple blunt force injuries.

2.1.5 Pilot's Post-Accident Toxicological Testing

The FAA's Civil Aeromedical Institute performed toxicology examinations for the pilot on December 17, 2013, which were negative for carbon monoxide and ethanol. The toxicological examination revealed 44.8 ug/ml of salicylate in the pilot's urine.

⁴ See attachment 3: Flight and Duty Records

Salicylate is an over-the-counter analgesic (commonly called aspirin) used in the treatment of mild pain.

3.0 The Airplane

The accident airplane was a 1998 model, Cessna 208B Grand Caravan, registration N12373, a single-engine turboprop aircraft. At the time of the accident, the airplane had logged a total time in service of 12,653 flight hours. The airplane was maintained under an approved aircraft inspection program (AAIP), and the most recent inspection of the airframe and engine was on November 12, 2013.

The airplane was equipped with a Pratt and Whitney PT6A-114A turbine engine that was rated at 675 shaft horsepower. The engine was overhauled 4,655 hours before the accident.

3.1 Airplane Performance

3.1.1 Weight and Balance

The following information was obtained from the flight manifest, maintenance records, and operator interviews:

Basic Operating Weight	5256.24 lbs.
Pilot + flight kit	214 lbs.
Passenger Weight	1,118 lbs.
Baggage & Cargo	225 lbs.
Zero Fuel Weight	6813 lbs.
Fuel	1600 lbs.
Ramp Weight	8413 lbs.
Taxi Fuel Burn	20 lbs.
Takeoff Weight	8393 lbs.
Max T/O weight allowed (payload extender)	9062 lbs.

CG Range (according to the operator's calculations)

FWD Limit: -10

C.G.: -6.5

AFT Limit: -0.3

4.0 Aerodrome Information

4.1 Mountain Village Airport

The Mountain Village Airport is a public airport in Class Echo airspace, located 2 miles northeast of Mountain Village, Alaska, at a surveyed elevation of 339 feet. The airport had one

open runway (2/20), at the time of the accident. Runway 2/20 is 3501 feet long and 75 feet wide and is serviced by an RNAV (GPS) instrument approach.

4.2 St. Mary's Airport

The St. Mary's Airport is a public airport in Class E airspace, located 4 miles west of St. Mary's, Alaska, at a surveyed elevation of 312 feet. The airport had two open runways (17/35, and 6/24), at the time of the accident. Runway 17/35 was 6008 feet long and 150 feet wide, and runway 6/24 was 1520 feet long and 60 feet wide.

Runway 17 was equipped with high intensity runway edge lights, a visual approach slope indicator (VASI), and 1,400 feet medium intensity approach lighting system with runway alignment indicator lights (MIRL). It was serviced by LOC/DME and RNAV (GPS) instrument approaches.

Runway 35 was equipped with high intensity runway edge lights and a VASI and serviced by a RNAV (GPS) instrument approach.

5.0 Company Overview

Hageland Aviation Services is a 14 CFR Part 135 air carrier that holds on-demand and commuter operations specifications. The air carrier is authorized to conduct business exclusively under the business names "Hageland Aviation Services, Inc." or "Era Alaska." The company headquarters is located at the Ted Stevens Anchorage International Airport, Anchorage, Alaska. The president, director of operations, and chief pilot all reside in Anchorage. The director of maintenance resides in Palmer, Alaska.

At the time of the accident, Hageland was operating 56 airplanes, employing about 130 pilots, with 12 bases located throughout Alaska, at Anchorage, Palmer, Aniak, Barrow, Bethel, Deadhorse, Fairbanks, Galena, Kotzebue, Nome, St. Mary's, and Unalakleet.

5.1 Operations Management

The Hageland Aviation Services Inc. General Operations Manual (GOM), section 1.1, described the company's organization, including its organizational chart⁵, and the duties and responsibilities of managers. Pilots were supervised by the chief pilot, who reported to the director of operations who in turn reported to the company president. Flight coordinators were supervised by the director of operations and base managers, both of whom reported to the company president. The GOM identified the 14 CFR Part 119 required management personnel, and the Operations Specifications paragraph A008, dated January 2, 2013, referenced the GOM for individuals authorized to exercise operational control.

5.1.1 Director of Operations

The GOM section 1.2.2 stated that the director of operations (DO) had the overall authority and ultimate responsibility for operational control of all flights. In addition to other duties, he established

⁵ See attachment 4: Hageland Aviation Services Organizational Chart

and administered an approved training program for pilots and personnel who were directly involved with operational control and directed the activities of the operations department employees and base flight coordinators. He was also responsible for maintaining a record keeping and audit program for required flight operations, pilot and training records, and the content, currency and distribution of the GOM and Company Operations Training Manual.

In an interview, the DO, Mr. Patrick Thurston, stated that he had served as the DO for about ten years, but was removed from the position shortly after the accident. He described his relationship with the FAA as professional and cooperative but stated there was not much interaction. The DO was responsible for operational control, and he delegated that authority to certain flight coordinators.

5.1.2 Assistant Director of Operations

The GOM section 1.2.3 stated that the assistant DO has authority and accountability for operational control as directed by the DO. In addition to other duties, he monitored operational control practices to improve reliability and efficiency and trained station personnel with operational control responsibilities.

5.1.3 Chief Pilot

The GOM section 1.2.4 stated that the chief pilot was an active member of the operational control team and promoted compliance with operational control objectives. He had the authority and responsibility to manage all company pilots, selection for hire, assignment to training, and evaluation of professional progress. He also determined the content for pilot training, communicating regularly with the director of operations training.

5.1.4 Flight Coordinator

The GOM section 1.2.12 stated that the flight coordinators reported directly to the DO for performance of flight coordinator duties. They were to successfully complete flight coordinator training, maintain flight coordinator qualification, and inform the base manager before any qualification expires. In addition to other duties, flight coordinators made flight assignments and released flights to operate according to the operational control chapter of the GOM. For every flight, they are required to consider the elements of risk and determine with the PIC the flight's risk assessment level enter the risk level on the manifest before offering it to the PIC, and verbally confirm that the flight can safely begin.

The flight coordinator who exercised operational control of the accident flight, Mr. Kenny Miller, was first hired by the company in 2009, he left in February 2012, and was rehired on June 6, 2012. He held an aircraft dispatcher certificate that was issued August 23, 2005, and completed initial company flight coordinator training in June of 2009. No records were provided that indicated he had participated in recurrent flight coordinator training, nor did he recall having participated in any such training.⁶

⁶ The company's recurrent flight coordinator training is further discussed in section 5.3.1 of this report.

The flight coordinator who prepared the manifest for the accident flight, Mr. John Flynn, completed initial flight coordinator training on October 1, 2013.

No records were provided that indicated either flight coordinator, working the accident flight, had been trained on the procedures and processes of the risk assessment program.

5.2 Company Operational Control Procedures

5.2.1 Operations Specifications Paragraph A008, Operational Control

A 14 CFR Part 135 operator must have a system and/or procedures for the control of flight movements. The intent of operations specification paragraph A008 is to promote a mutual understanding between an operator and the FAA concerning the system and/or procedures used by that operator.

Operations Specifications Paragraph A008⁷ (Operational Control) was issued to Hageland Aviation Services by the FAA on January 2, 2013, and stated in part:

(1) The Operational Control processes for Hageland Aviation Services, Inc. will be conducted by the individuals listed in the Hageland Aviation General Operations Manual Section 2.1.5 B2.; records of which are kept at the company main office

(2) These responsibilities are not transferable to any other person or entity.

(3) The responsibility for safe operational control by Hageland Aviation supersedes any agreement, contract, understanding or arrangement, either oral or written, expressed or implied between any persons or entities.

(4) The Operational Control processes for Hageland Aviation Services, Inc. shall be conducted in accordance with Hageland Aviation General Operations Manual Section 2.1

The DO stated in an interview that the company does not keep a list of current operational control delegates, but a list of flight coordinators that have completed training is maintained by the operations training department.

The Chief Pilot stated in an interview that he maintained a list of pilots who could be delegated operational control, and he thought the DO maintained a list of flight coordinators. He also stated that there is an operational control delegate list that the DO provides to all the stations.

In an interview, the current POI stated that a list of operational control delegates is kept in the DO's office; he did not like the fact that the list was separate from the GOM or Ops Spec A008; and he thought about 35 to 40 people were authorized to exercise operational control. He also stated that according to the GOM, all PICs could exercise operational control for flights that they were not assigned to as the flight crew.

⁷ See attachment 5: Operations Specifications Paragraph A008

No list of operational control delegates was provided, and GOM section 2.1.5 B2 did not contain a list of individuals authorized to exercise operational control.

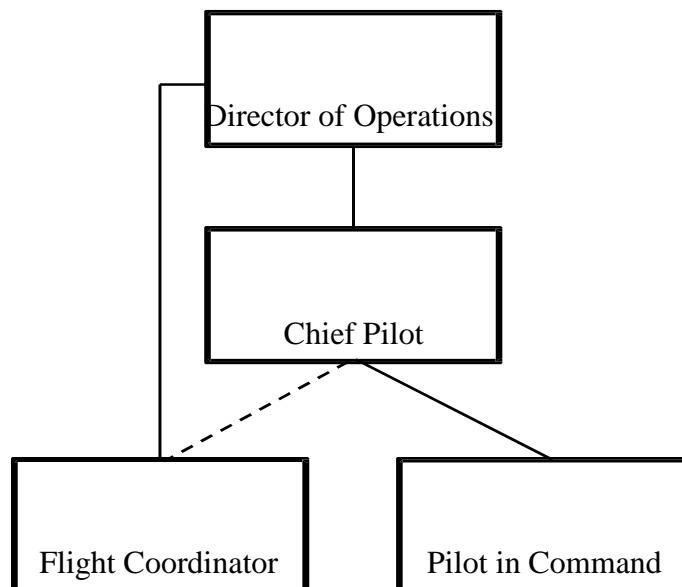
5.2.2 Hageland General Operations Manual Section 2.1

Hageland Aviation Services Inc. GOM, section 2 describes the company's process for operational control, and defined operational control as the exercise of authority over initiating, conducting, or terminating a flight.

The GOM, Revision 2, dated October 30, 2013, stated that the DO is responsible for operational control, and that he delegated authority to exercise tier 1⁸ operational control of any flight to the Flight Coordinator. The GOM went on to say, that the DO also delegated authority to exercise tier 1 operational control to the Chief Pilot, who then delegated the authority to exercise tier 1 operational control to the PIC.

The GOM stated in part:

“The flight coordinator and PIC are jointly responsible for preflight planning, flight delay and release of a flight in compliance with FAR, the Ops Specs, and the procedures of this manual”.



In all, approximately 80 flight coordinators and 96 company pilots were allowed to exercise tier 1 operational control and release flights on behalf of the certificate holder.

The DO stated in an interview that he was responsible for operational control but delegated that authority to certain flight coordinators. He relied on station managers and PIC's to supervise

⁸ The definition of Tier 1 operational control is defined in section 6.1.1 of this report.

operational control delegates. Management sampled the delegates work by visiting stations and telephone conversations, but they did not document this short of a major event.

The chief pilot stated in an interview that he is an active member of the operational control team, and could delegate operational control to the pilots.

The current POI stated in an interview that the DO has ultimate responsibility for operational control and delegates that responsibility to the flight coordinators. Flight coordinators in conjunction with the PIC decide whether a flight can be released. The Director of Operations, Chief Pilot, Assistant Chief Pilot, PICs, and flight coordinators were all are allowed to exercise tier 1 operational control on behalf of the certificate holder.

5.2.1 Company Risk Assessment Program

In the September 2013, Hageland Aviation Services introduced a Risk Assessment Program as part of their operational control procedure. It was a 4-tiered numbered system, with 1 being the lowest risk and 4 being the highest risk. A risk level of 1 required no risk mitigation, a level 2 required a meaningful discussion between the pilot and flight coordinator about the risks involved, a level 3 required a phone call to management, and a level 4 would cancel the flight. At the time of the accident, there was no signoff required for flight coordinators or pilots on the risk assessment sheet, and it was not integrated into the company manuals.

The DO stated in an interview that the new risk assessment was implemented in September 2013 as part of their operational control procedures. It was not accepted, approved, or required by the FAA, and was not integrated into their GOM. He said that pilots were “lightly trained” on the new procedure. When asked if flight coordinators were trained, he stated he was sure they were, but could not recall a particular event, and said that the training was not documented.

The flight coordinator who exercised operational control of the accident flight stated in an interview that the risk assessment program was fairly new and was a part of the company’s operational control procedures. He had not received any training on the risk assessment program.

The chief pilot stated in an interview that the risk assessment program was a tool used in operational control; it was presented and accepted by the FAA, and implemented in September 2013. It was not currently contained in the GOM, but “that was logical.” Pilots were trained via an online training program, but he was not aware if flight coordinators were required to take the online course.

The current POI stated that he was not assigned to the Hageland certificate when the risk assessment program was implemented, and therefore, he was not sure why the risk assessment process was not integrated into the company manuals.

The former POI stated in an interview that he vaguely remembered a risk assessment program being presented in a company meeting and was not sure if company personnel had been trained or if the program had been integrated into the company’s manuals.

5.3 Operations Training Manual

5.3.1 Flight Coordinator Training

Hageland Aviation Services Inc., Operations Training Manual, section 1-11-9, described the flight coordinator training. There were no prerequisites required to enter flight coordinator training. Initial flight coordinator training consisted of 8 hours of classroom time, and recurrent consisted of about 3 or 4 hours depending on the experience of the student. Both initial and recurrent training covered the following subjects:

1. Pertinent regulations
2. Airplane Status, Maintenance and DMI
3. Crew Duty
4. Hazardous Materials Recognition, Acceptance and Handling
5. Communications and Records
6. Weather
7. Fuel Planning
8. Flight Planning
9. Load Planning
10. Aeronautical Decision Making, Human Factors
11. Emergencies – Emergency Section of GOM
12. Flight Master, Risk Assessment
13. Test

The DO stated in an interview that flight coordinator training consisted of classroom exercises and a written test, followed by observation of initial work. The classroom portion was about 6 to 8 hours long, and no recurrent training was required.

6.0 Additional Information

6.1 FAA Guidance on Operational Control

6.1.1 FAA Order 8900.1 Two-Tiered Operational Control Concept

FAA Order 8900.1, Volume 3, Chapter 25, Section 5⁹, 3-2029, H, states in part:

The first tier is described as the assignment of flight crewmembers, and aircraft for revenue service under the operating certificate, and must be made by management or management delegates. In order to be delegated the authority to make these decisions, the management delegates must be trained, found competent, and designated by the certificate holder, be listed in the GOM, and be under management supervision. Management supervision means, that the certificate holder tracks the actions of the management delegate or employee, samples the work of that employee (reviews a sample of the decisions made), and has the ability to enforce the certificate holder's standards through corrective actions such as retraining, requalification, or disciplinary actions

⁹ See attachment 6: FAA Order 8900.1, Volume 3, Chapter 25, Section 5

such as disqualification, demotion, suspension, or termination. Because the certificate holder is responsible for the conduct of its employees or agents, it must have the ability to monitor and control their performance.

The second tier is more tactical and may be taken either by the certificate holder's direct employees or by the certificate holder's agents. This involves the decisions made by personnel (such as the PIC) in the day-to-day conduct of operations. This may include the initiation of flights upon the PIC receiving a request from the customer directly (often the case in on-demand operations being conducted under a dedicated service contract, such as offshore operations or emergency medical service). This is acceptable if the PIC is authorized by the certificate holder to make those decisions on behalf of the certificate holder. To do so would require that the PIC be trained, found competent by the certificate holder, designated, be listed in the GOM (or in OpSpec A006, A039 or A040, if applicable), and be under management supervision. If maintaining a list of these personnel in the GOM is too cumbersome, a list of these personnel may be maintained at the air carrier's principal base of operations and referenced in the GOM. The method of maintaining and distributing this list to all affected parties must be described in A008 or in the GOM.

The GOM (or other appropriate documentation) must contain guidance which describes the certificate holder's operational control system. The training program must provide the certificate holder's personnel with the knowledge and skills required to ensure that the operational control system is effective.

6.1.2 FAA Order 8900.1 Summary of Operational Control

FAA Order 8900.1, Volume 3, Chapter 25, Section 5, 3-2029, K, states in part:

Only approved persons may exercise operational control on the certificate holder's behalf.

The certificate holder must have adequate controls in place to ensure that officials in a position of authority over flights conducted under the certificate do so safely, and in compliance with the regulations, OpSpecs, GOM, as applicable, and accepted or approved procedures.

Management of operations should never be inattentive, distracted, or careless. Hands-off management is not a legitimate excuse for failing to maintain operational control.

6.1.3 FAA Order 8900.1 Operational Control Failures

FAA Order 8900.1, Volume 3, Chapter 25, Section 5, 3-2029, F, states in part:

The level of severity of the failure in operational control will dictate the actions required by both the certificate holder and the FAA. Simple cases may require reinforcement or realignment of management structure or procedure. In such cases, administrative action may be acceptable. In more pronounced cases, civil penalty and/or certificate action may be appropriate.

The FAA has identified several failure modes of operational control, including at least the following basic conditions:

- 1) Loss of operational control within the air carrier—hands-off management results in inadequate controls over its own operations.*
- 2) Loss of operational control within the air carrier—exercise of operational control by an unapproved person.*
- 3) Loss or surrender of operational control externally; e.g., an air carrier's illegal renting/franchising-out the use of its air carrier certificate to one or more uncertificated entities.*

6.1.4 14 Code of Federal Regulations Part 119, Sec. 119.69

14 CFR 119.69, Management personnel required for operations conducted under part 135 states in part:

That anyone in a position to exercise control over operations conducted under the operating certificate must be qualified through training, experience, and expertise, and to the extent of their responsibilities, have a full understanding of the following material with respect to the certificate holder's operation; aviation safety standards and safe operating practices; 14 CFR Chapter I (Federal Aviation Regulations); the certificate holder's operations specifications; all appropriate maintenance and airworthiness requirements of this chapter (e.g., parts 1, 21, 23, 25, 43, 45, 47, 65, 91, and 135 of this chapter); and the manual required by Sec. 135.21 of this chapter; and discharge their duties to meet applicable legal requirements and to maintain safe operations.

The current POI stated in an interview that the FAA required Hageland to develop a training program for flight coordinators, which required testing. The flight coordinators had to be trained and found competent. He stated (while looking at a copy of 119.69) that he was not sure if the training alone met all the requirements of the regulation for operational control personnel.

6.1.5 14 Code of Federal Regulations Part 135, Sec 135.77

14 CFR 135.77, Responsibility for Operational Control

Each certificate holder is responsible for operational control and shall list, in the manual required by Sec. 135.21, the name and title of each person authorized by it to exercise operational control.

7.0 FAA Oversight

7.1 Anchorage Flight Standards District Office

The POI in the Anchorage Flight Standards District Office (FSDO) in Anchorage, Alaska, who was assigned to oversee Hageland Aviation Services Inc. had been employed with the FAA for about 7 years at the time of the accident. He had been temporarily assigned to the Hageland certificate from October 2012 to April 2013, and was permanently assigned to the certificate in September 2013, about 3 months before the accident.

The POI stated in an interview that during his temporary assignment to the certificate he sent a letter to the operator's management outlining areas of concern that he had identified, which included:

1. Develop a formal risk assessment.
2. Redefine company weather minimums making them more restrictive.
3. Institute flight authorization for certain high risk flights that required direct input from 119 management personnel.
4. Initiate 119 management visits to all bases.
5. Accomplish additional training on operational control.

When he was reassigned permanently to the certificate in September 2013, he began focusing on these previously identified items.

He also stated that it was difficult to hold the company accountable for the actions of their employees. The oversight required to ensure compliance was "tremendous", and he did not believe a standard CMT was sufficient.

The former POI could not recall specifically when he had been assigned to the Hageland certificate, but believed it to be from sometime in April 2013 to sometime in August 2013. He stated in an interview that he could not determine if a standard CMT was sufficient and felt that would be a management decision.

A frontline manager in the Anchorage FSDO supervised both the current and former POIs. He stated in an interview that in the last 2 ½ years Hageland Aviation Services Inc. had 6 POI changes, with 5 different POIs being assigned to the certificate. He also stated that a standard CMT of three people would be sufficient if Hageland's reduced its fleet size or did a better job overseeing itself, but currently they were just too big. He stated that he had tried every avenue he could think of to request additional inspectors be assigned to the Hageland certificate, and he felt the accidents may have been avoided if the operator had done a better job of policing itself, or if the FAA had been able to provide better oversight.

7.2 Surveillance Activities

The Program Tracking and Reporting Subsystem (PTRS) is a computer based information analysis system used by the FAA as a standard method of collecting data for recording Aviation Safety Inspector surveillance activities. PTRS entries for the Hageland certificate for the time period November 1, 2011 to November 30, 2013 were reviewed by the operations group chairman and the following entries were noted.

On July 16, 2013, an FAA safety inspector conducted an Operational Control Inspection (code 1636) at the company's base in Nome. The base had a new manager and 4 ticket agents sharing flight coordinator duties. The inspector noted in part: "They had not received any formal training, and were attempting to manage customer service, flight manifests, flight coordination and other duties at the same time".

On July 17, 2013, an FAA safety inspector conducted an Operational Control Inspection (code 1636) at the company's base in Kotzebue. The inspector noted in part: "Conclusion: although the risk-assessment appears to have been implemented, it is not functioning correctly due to non-involvement of the pilots. There did not appear to be sufficient staff at this facility on the day it was inspected."

On August 15, 2013, an FAA safety inspector conducted an Operational Control Inspection (code 1636) at the company's base in Aniak. The inspector observed multiple GOM violations and noted in part: "As these are GOM violations, which is FAA accepted, there may not be the ability to enforce these differences between the GOM and observed procedures/operation."

On October 16, 2013, the POI conducted an Operational Control Inspection (code 1636) at the company's base in Bethel. The POI noted in part: "Flight Coordinators then placed a Risk Assessment value on the Flight Manifest. Most times the POI saw no discussion take place on this value or any conditions that may change this value."

On October 22, 2013, the POI contacted the DO and discussed in part: "Issues involving failures of the risk assessment program and advised the company to form a specific time line for completion of the implementation of the process and training of personnel in writing and submit no later than 12/1/2013."

7.3 Enforcement Records

The Enforcement Information System (EIS) is the FAA's primary database for tracking and reporting information about enforcement actions for statutory or regulatory violations.

EIS records provided by the FAA indicated that FAA inspectors observed 11 incidences of noncompliance related to flight operations by the operator and opened investigations. From July 2009 until the November 29, 2013 accident, the 11 noncompliance investigations were closed with no action taken greater than administrative action.

The current POI stated in an interview that in April of 2013 he had put together what he believed to be a robust operational control enforcement case against the operator and forwarded it through the proper chain to FAA legal counsel for evaluation. The case was not pursued, and he received no feedback as to why. He was gathering evidence to remove the DO from his position when the accident occurred.

The POI's frontline manager stated in an interview that the POI had written an operational control enforcement case against the company but the case had not been pursued because operational control is a regulation that is difficult to enforce. He also stated that the issues

involved in the St. Mary's accident instigated another operational control enforcement case that was pending.

F. List of Attachments

Attachment 1: Interview summaries

Attachment 2: Company Personnel Records

Attachment 3: Flight and Duty Records

Attachment 4: Hageland Aviation Service's Organizational Chart

Attachment 5: Operations Specifications Paragraph A008

Attachment 6: FAA Order 8900.1, Volume 3, Chapter 25, Section 5

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Air Safety Investigator